90-1694

Supreme Court, U.S.
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No.

IN THE SUPREME COURT OF THE UNITED STATES

October Term 1990

EDWARD LINGERFELT,

Petitioner,
v.

COMMERCIAL INSURANCE COMPANY OF NEWARK, N.J.,

Respondent.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Did the court below err in failing to apply the federal common law of ERISA to construe the term "accident" as used in petitioner's disability insurance policy, thereby denying petitioner his rights to disability insurance benefits, in conflict with the decisions of other federal circuit courts of appeal?

2. Did the court below err in failing to apply the federal common law of ERISA to construe an insurance policy exclusion provision which provided for coverage of accidents "resulting directly and independently of all other causes," thereby denying petitioner his rights to disability insurance benefits, in conflict with the decisions of other federal circuit courts of appeal?

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OPINIONS BELOW

The decision of the United States Court of Appeals for the Sixth Circuit is an unpublished opinion (*infra* at A-29), filed on February 5, 1991, and noted at *Lingerfelt v. Nuclear Fuel Services, Inc.*, 924 F.2d 1058 (6th Cir. 1991). The magistrate presiding over trial of the action entered a Memorandum Opinion (*infra* at A-1) and a judgment (*infra* at A-28), both unpublished, against petitioner on February 9, 1990 in the United States District Court for the Eastern District of Tennessee, Northeastern Division.

JURISDICTION

Petitioner brought the instant action for the recovery of disability insurance benefits under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 *U.S.C.* §§ 1001 et seq., in the United States District Court for the Eastern District of Tennessee. Pursuant to an agreement of the parties, the action was tried before a United States Magistrate on January 25 and 26, 1990, without a jury.

On February 9, 1990, the magistrate filed a memorandum opinion and an accompanying order denying petitioner's claim to disability insurance benefits (A-1; A-28).

Petitioner appealed this judgment, as to defendant below and respondent herein, Commercial Insurance Company, to the United States Court of Appeals for the Sixth Circuit. Defendants below Continental Insurance Company and Nuclear Fuel Services were not parties to the appeal nor are they respondents herein.

On February 5, 1991, the United States Court of Appeals for the Sixth Circuit filed its decision affirming the judgment of the magistrate below (A-29).

The jurisdiction of this Court to review the judgment of the United States Court of Appeals for the Sixth Circuit is invoked pursuant to 28 *U.S.C.* § 1254(1).

STATUTORY PROVISIONS INVOLVED

Petitioner brought the instant action under the comprehensive statutory provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 *U.S.C.* §§ 1001 et seq. Specifically, petitioner instituted his action in the United States District Court pursuant to the specific authority conferred by Title 29, *U.S.C.* § 1132(a), which provides:

> § 1132. Civil enforcement
>
> (a) Persons empowered to bring a civil action. A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> . . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

STATEMENT OF THE CASE

On October 6, 1987, petitioner Edward Lingerfelt suffered a back injury while in the employ of Nuclear Fuel Services, Inc. (NFS) (Magistrate's Decision at 1; A-1). Specifically, this injury occurred when petitioner and two coworkers attempted to lower a motor from a roof of a building to the floor by means of a long rope attached to the motor (Magistrate's Decision at 12; A-11). As the three employees were lowering the motor from the roof to the floor, petitioner felt the rope jerk, and immediately thereafter felt a "pop" or "catch" in his back (Magistrate's Decision at 12; A-11). Following this injury, petitioner experienced severe back pain, which continues to the present day and which has made it impossible for the petitioner to return to his employ with NFS (Magistrate's Opinion at 12-16; A-11-14).

Expert witness testimony adduced at trial below established that, prior to sustaining the October 6, 1987 injury, petitioner had suffered other back injuries in the past, and that petitioner's preexisting back condition had contributed to the seriousness of his October 6, 1987 injury (Magistrate's Decision at 15-16; A-13-14). However, the expert witness testimony also established that the October 6, 1987 accident was the precipitating cause of petitioner's removal from work and led to petitioner's failure to return to gainful employment to the present day (Magistrate's Decision at 15-16; A-13-14).

Following his debilitating injury of October 6, 1987, petitioner claimed the disability insurance benefits provided for in his employee group accident disability insurance plan, on the grounds that, as a result of the October 6, 1987 accident, he had become totally and permanently disabled from his occupation with NFS and any other occupation (Magistrate's Decision at 4; A-3-4). Petitioner sought

to recover the principal sum of the group disability insurance policy from respondent insurance company.

Upon respondent's denial of petitioner's claim for disability insurance benefits, petitioner instituted the instant action, pursuant to ERISA, to recover benefits due him under his disability insurance policy, as governed by ERISA (Magistrate's Decision at 2; A-2). Respondent conceded that petitioner's action arose under ERISA, as the disability insurance policy in question was an employee group disability insurance policy covered by ERISA (Magistrate's Decision at 5; A-4).

At trial, respondent admitted that petitioner complied with all requirements of the subject insurance policy for making the claim pursuant to the policy, but denied liability to petitioner based on two grounds of defense (Magistrate's Decision at 4; A-4). First, respondent contended that petitioner was not involved in an "accident" on October 6, 1987 within the meaning of the coverage provisions of his group disability insurance policy (Magistrate's Decision at 4; A-4). Second, respondent contended that even if petitioner had suffered an "accident" within the meaning of the terms of the insurance policy, nevertheless petitioner could not recover on the policy for such an accident, as the accident was not a "loss resulting directly and independently of all other causes" within the meaning of the exclusions from coverage contained in the insurance contract (Magistrate's Decision at 4; A-4). Respondent further contended that petitioner's disability arose in whole or in part from petitioner's degenerative disc disease which predated the October 6, 1987 accident and for which petitioner could not recover under the disability insurance policy (Magistrate's Decision at 4; A-4).

Following trial of the case, the magistrate filed his memorandum opinion on February 9, 1990, denying

petitioner's claim to disability insurance benefits. In his decision, the magistrate recognized that the federal courts should develop a federal common law regarding the construction of insurance policies governed by ERISA (Magistrate's Decision at 18-19; A-16). The magistrate went on to note that such federal common law should be derived from state law if state law is compatible with federal policy, and concluded that in the instant case state law was compatible with federal policy (Magistrate's Decision at 19; A-16-17).

The magistrate found that petitioner had not suffered an "accident," as that word is defined under the appellate decisions of the courts of Tennessee—the forum state of the instant litigation; the magistrate further found that, in any event, petitioner did not suffer an accidental loss "resulting directly and independently of all other causes" as provided in the exclusions from coverage set forth in the disability insurance policy in question (Magistrate's Decision at 27-29; A-24-26). The court concluded that petitioner could not qualify for disability insurance benefits under the relevant portions of the subject plan, under either state or federal law (Magistrate's Decision at 30; A-26).

The United States Court of Appeals for the Sixth Circuit affirmed the decision of the magistrate and held that petitioner was not entitled to disability insurance benefits under the federal common law of ERISA, as applied to the provisions of the insurance plan in question, because petitioner did not have an "accident," and because if petitioner had had an "accident," recovery was nevertheless precluded by the specific exclusions from coverage contained in the insurance policy in question (Appellate Decision at 10-11; A-38-39).

Significantly, the decision of the Court of Appeals

specifically characterized the October 6, 1987 incident as an "accident" at one point in its opinion, and noted that expert witness testimony at trial had established that the "accident" was the precipitating cause which led to petitioner's removal from work and his failure to return to gainful employment (Appellate Decision at 5; A-33). However, later in its decision, the appellate court specifically concluded that the petitioner had *not* suffered from an "accident" and that petitioner's recovery of benefits was therefore barred (Appellate Decision at 8; A-35).

In affirming the magistrate's decision, the circuit court concluded that where the petitioner—who admittedly suffered from a preexisting disc disease prior to his October 6, 1987 injury—engaged in the lifting of a heavy weight, which precipitated the 1987 injury, "the resulting disability more closely resembled an inevitable consequence than an unforeseen accident" (Appellate Decision at 7; A-35). The circuit court then noted that the disability insurance policy in question covered only "accidents" and concluded that petitioner did not have an accident within any reasonable meaning of that term (Appellate Decision at 8; A-35).

In addition, the appellate court noted that the insurance policy in question did not insure for illness or disease, but only insured against accidents "resulting directly and independently of all other causes" (Appellate Decision at 2-3; A-30-31). Based on the exclusionary language of the insurance policy, the court denied petitioner's claim to benefits, stating: "[M]*ost importantly for us*, [Petitioner's] situation falls within the clear language of the policy exclusions" (Appellate Decision at 11; A-38 (emphasis added)).

In affirming the magistrate's decision, the appellate court recognized that in enacting ERISA, Congress intended to establish the regulation of employee benefit plans as an exclusive federal concern, and that in constru-

ing the provisions of employee benefit plans governed by ERISA, the federal courts are required to develop a federal common law consistent with the ameliorative public policies underlying the enactment of ERISA (Appellate Decision at 9-10; A-36-38).

The circuit court held that under this emerging federal common law it would adhere to the literal language of accident insurance contracts, except where public policy considerations underlying ERISA required a different construction (Appellate Decision at 9-10; A-36-38). The appellate court recognized that the congressional objective in enacting ERISA was to assure that those who participate in employee benefit plans actually receive the benefits to which they are entitled and do not lose benefits as a result of unduly restrictive provisions (Appellate Decision at 10; A-37-38).

The appellate court concluded that it could construe literally the coverage and exclusion provisions of the insurance policy in question without running afoul of the public policy considerations which underlie the enactment of ERISA and which are required to be implemented into the emerging federal common law of ERISA. The court denied petitioner's claim to disability benefits on the grounds that petitioner had not suffered an "accident" as that term was used in the insurance policy because the injury in question was objectively foreseeable, and, furthermore, because "most importantly . . . , Lingerfelt's situation falls within the clear language of the policy exclusions" (Appellate Decision at 10-11; A-38).

The decision of the circuit court of appeals affirming the magistrate's decision was entered on February 5, 1991. This petition followed.

REASONS FOR GRANTING THE WRIT

I. THE COURT BELOW ERRED IN FAILING TO APPLY THE FEDERAL COMMON LAW OF ERISA TO CONSTRUE THE TERM "ACCIDENT" IN PETITIONER'S DISABILITY INSURANCE POLICY, THEREBY DENYING PETITIONER HIS RIGHTS TO INSURANCE DISABILITY BENEFITS, AND THE ERROR OF THE APPELLATE COURT IS IN CONFLICT WITH THE DECISIONS OF OTHER FEDERAL CIRCUIT COURTS OF APPEAL REGARDING AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, RESOLVED BY THIS COURT, CONSISTENT WITH THE PRIOR DECISIONS OF THIS COURT REGARDING ERISA.

A.The Development Of A *Uniform* Body Of Federal Common Law Governing ERISA Actions Is Necessary To Achieve The Purposes Of ERISA.

The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 *U.S.C.* §§ 1001 et seq., was enacted by Congress for the purpose of assuring that persons who participate in employee welfare benefit plans actually receive the benefits to which they are entitled and that such persons do not lose these benefits as a result of unduly restrictive provisions or lack of sufficient funds. *See H.R. Rep.* No. 93-807 93d Cong., 2d Sess. 3, *reprinted in* 1974 *U.S. Code Cong. & Admin. News* 4639, 4670, 4676-77. Under ERISA, the beneficiary of an employee welfare benefit plan, such as the employee group disability insurance policy at issue

in the instant case, is specifically empowered to bring an action in the federal courts to recover any benefits due the beneficiary under the terms of such an ERISA plan. 29 *U.S.C.* § 1132(a)(1)(B).

In construing the provisions of ERISA, in the context of civil actions brought under the foregoing statute by beneficiaries of ERISA plans for the recovery of benefits due under particular ERISA plans, this Court has recognized that insurance coverage which is part of an ERISA plan is regulated under ERISA. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 48 (1987). Furthermore, in construing ERISA in the context of ERISA beneficiaries' claims to benefits under ERISA plans, this Court has recognized that the various federal courts must develop a federal common law of rights and obligations of ERISA-regulated plans. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-14 (1989). Moreover, this Court has recognized that ERISA was enacted to promote the interests of employees and the beneficiaries of employee benefit plans. *Id.* at 113.

In evaluating claims to benefits under insurance policies which are regulated by ERISA, several federal circuit courts of appeal have recognized that in construing the provisions of an insurance policy which is governed by ERISA, the federal courts must construe such policies with reference to the emerging federal common law of ERISA, rather than with reference to state laws and state-court decisional authority relating to insurance policies. *See Wickman v. Northwestern National Insurance Co.*, 908 F.2d 1077 (1st Cir. 1990), *cert. denied*, 59 U.S.L.W. 3418, 3420 (1991); *Adkins v. Reliance Standard Life Insurance Co.*, 917 F.2d 794 (4th Cir. 1990); *Evans v. Safeco Life Insurance Co.*, 916 F.2d 1437 (9th Cir. 1990). Moreover, at least one federal circuit court of appeals has recognized, in view of the provisions of ERISA and the prior decisions of this Court with

respect thereto, that although it may be acceptable for a federal court to look to the developed law of a particular state in attempting to develop a federal common law of ERISA, it would contravene the underlying policies of ERISA if, in developing the federal common law of ERISA, the federal courts were to develop 50 different sets of applicable federal common law, each to be applied with reference to the insurance laws in effect in the forum state. *See Evans v. Safeco Life Insurance Co., supra.*

In *Evans v. Safeco Life Insurance Co., supra*, the United States Court of Appeals for the Ninth Circuit noted that several prior decisions of this Court have clearly indicated that a critical concern to the federal courts in the development of a federal common law of ERISA must be the development of a *uniform* federal common law of ERISA which will not fluctuate depending upon the laws of the forum state within which a federal court entertaining an ERISA claim is situated. 916 F.2d at 1440 (citing *Pilot Life Insurance Co. v. Dedeaux, supra*, 481 U.S. at 56; *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 99-100 (1983); *see also Sampson v. Mutual Benefit Life Insurance Co.*, 863 F.2d 108 (1st Cir. 1988)).

In *Evans v. Safeco Life Insurance Co., supra*, the Ninth Circuit Court of Appeals was confronted with an employee's claim to insurance benefits under an insurance policy governed by ERISA. The employee sought to recover benefits under a provision of the insurance policy in question which provided for coverage of an employee's children. The employee's stepson (possibly his biological son) was killed in an accident, and the employee applied for accidental death benefits under the policy provisions covering employees' children. The insurer denied coverage, on the grounds that the decedent was not the employee/claimant's "child."

The appellate court in *Evans* addressed the threshold question of how the term "child" in the insurance policy in question should be construed, and concluded that the definition of the term "child" must be interpreted with reference to a *uniform* federal common law of ERISA, rather than with reference to the state decisional law of the forum state. In arriving at a definition of the term in question, the appellate court considered various definitions of the term "child" which had been developed by various state courts, and adopted the definition which seemed most reasonable and most widely accepted in numerous jurisdictions and by numerous commentators. The import of the *Evans* decision lies in the fact that the circuit court of appeals in that case recognized the necessity of developing a *uniform* federal common law of ERISA under which insurance plans governed by ERISA could be interpreted, particularly with respect to the definition of the coverage terms used in such policies.

B.The Emerging Federal Common Law Of ERISA, As Developed In Other Federal Circuits, Mandates A More Reasonable Definition Of The Term "Accident" Than That Adopted By The Court Below In Denying Petitioner Insurance Benefits.

In *Wickman v. Northwestern National Insurance Co.*, *supra*, the United States Court of Appeals for the First Circuit reviewed a beneficiary's claim to insurance benefits due under an insurance policy governed by ERISA. The insurer had denied coverage on the basis that the insured's death was not the result of an "accident," thereby negating the claimant/beneficiary's rights to double indemnity benefits under the insurance policy in question.

In *Wickman*, the employee insured by the ERISA-governed insurance policy was killed when he fell to his death from a highway overpass. The insurer denied the claims of

the employee's widow to double indemnity accidental death benefits under the insurance policy in question, on the grounds that the employee had intentionally hurled himself to his death and had not suffered an "accident" within the coverage of the insurance policy. In reviewing the matter, the First Circuit Court of Appeals recognized that in order to determine the rights of the parties to the action, the court must adopt a definition of the term "accident" as a part of the emerging federal common law of ERISA, rather than accepting the definition of the term "accident" as defined by the state decisional law of the forum state of the litigation.

In order to develop a definition of the term "accident" within the framework of ERISA, the court in *Wickman* embarked on an analysis of the definitional law which has developed in various states over the years with respect to construction of the term "accident." In its analysis, the circuit court noted that the traditional approach to the definition of the term "accident" had led several state appellate courts in the past to hold that where an incident which might otherwise be termed an accident was the result of activity which, in hindsight, might have foreseeably or predictably resulted in injury, the injury would not be considered an "accident" for purposes of recovering under an insurance policy which insured against accidents.

In rejecting this traditional distinction between accidental means and accidental results, the *Wickman* court noted that such a distinction was not in keeping with the understanding of the average citizen:

> In recent years, courts consistently have rejected the distinction between accidental means and accidental results noting that:

> it is illogical to purport to distinguish between the accidental character of the result and the means which produce it; that the distinction gives to "accidental means" a technical definition which is not in harmony with the understanding of the common man; and that the ambiguity found in the concept should be resolved against the insurer so as to permit coverage.
>
> 10 *Couch on Insurance 2d* § 41:31, 50 (1982); *see also Page Flooring and Constr. Co. v. Nationwide Life Ins. Co.*, 840 F.2d 159, 162 (1st Cir.1988) (Coffin, J., dissenting) (urging the interpretation prevailing in an increasing number of jurisdictions that the two terms be construed as synonymous and rejecting the distinction between "accidental means" and "accidental results" as artificial and confusing). Having reviewed the pertinent state court decisions, we conclude that the better reasoning rejects the distinction. Thus, we elect to pursue a path for the federal common law which safely circumvents this "Serbonian Bog."

908 F.2d at 1086.

The court concluded that whether a person suffers an accident or not should be determined from a subjective analysis of the insured person's reasonable expectations as to whether certain activity would result in injury, rather than from an analysis of an injury in the context of whether, in hindsight, others might believe that a particular injury was foreseeable or predictable based on the activity

leading up to the injury in which the injured person was engaged. In carrying out this analysis, the *Wickman* court held that the insured's expectations should be given the benefit of the doubt, as follows:

> [T]he reasonable expectations of the insured when the policy was purchased is the proper starting point for a determination of whether an injury was accidental under its terms.
>
> If the fact-finder determines that the insured did not expect an injury similar in type or kind to that suffered, the fact-finder must then examine whether the suppositions which underlay that expectation were reasonable. *See New York Life Ins. Co. v. Harrington*, 299 F.2d 803, 806 (9th Cir. 1962). This analysis will prevent unrealistic expectations from undermining the purpose of accident insurance. If the fact-finder determines that the suppositions were unreasonable, then the injuries shall be deemed not accidental. *The determination of what suppositions are unreasonable should be made from the perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences. See, e.g., Ward v. Penn Mutual Life Ins. Co.*, 352 S.W.2d 413, 423 (Mo.Ct.App.1961) (finding accident where man fell off top of moving car; he had performed the stunt previously, knew, and trusted the driver, was strong, and had a good grip); *Oldring v. Metropolitan Life Ins. Co.*, 492 F.Supp. 994

> (D.N.J.1980) (finding an accident where owner experienced in use of gun, after having examined the gun and thinking it was empty, pointed and fired the gun at his head, killing himself); *Knight v. Metropolitan Life Ins. Co., supra*, (finding accidental the death of professional diver after diving off the Coolidge Dam; he previously had completed the same dive without injury).

Id. at 1088 (emphasis added).

C.The Appellate Court Below Erred In Applying The Distinction Between Accidental Means And Accidental Results In Determining That The Petitioner Did Not Suffer An "Accident."

As a review of the decisions of the courts below clearly indicates, both the trial court and the appellate court applied the antiquated distinction to the definition of the term "accident" still adhered to by the state courts of the forum state of Tennessee, placing great emphasis on the objective predictability and foreseeability of petitioner's injury in light of petitioner's preexisting back problems. In adopting this approach, the courts below wholly ignored the more reasonable analysis, adopted by many states over the past three decades, which addresses the question of whether a person has suffered an accident in terms of whether the injured person intended to injure him or herself, as opposed to whether a third party might, in hindsight, determine that an injury was objectively predictable or foreseeable.

As noted above in the Statement Of The Case, the magistrate below analyzed the events leading up to petitioner's injury under Tennessee insurance law and con-

cluded that under Tennessee insurance law the petitioner did not suffer an "accident." Under the Tennessee state-law analysis, although the injury which resulted from petitioner's activities in lowering the motor with his co-workers on October 6, 1987 might be termed an accidental *result*, the *means* by which the injury occurred was not accidental, in the sense that petitioner's voluntary act of lowering the motor precipitated the injury (Magistrate's Decision at 27-28; A-24-25). The magistrate held that in the instant case, Tennessee's state law was consistent with the principles underlying ERISA and would therefore be applied as the federal common law of ERISA, for the purposes of evaluating petitioner's claims under ERISA (Magistrate's Decision at 19; A-17). In analyzing the case under the federal common law of ERISA, the magistrate applied Tennessee state law in determining that no "accident" had occurred within the coverage of petitioner's insurance policy.

Similarly, the Circuit Court clearly applied the Tennessee state-law distinction between accidental means and accidental results in holding that petitioner did not suffer an "accident" covered under his disability insurance policy. Although the Circuit Court did not make specific reference to Tennessee state law on this subject, the analysis of the Circuit Court is clearly grounded in the distinction between accidental means and accidental results, as demonstrated by the court's failure to consider petitioner's subjective expectations, and by the court's reliance on the fact that a third-party objective observer might have foreseen that an injury could have resulted from the activity of lowering a motor.

The Circuit Court's opinion speaks of the injuries sustained by the petitioner in lowering the motor in terms of their objective foreseeability on numerous occasions throughout its decision. Early in the decision, the court

stated that petitioner's injury "more closely resembled an inevitable consequence than an *unforeseen* accident" (Appellate Decision at 7; A-35). Later, the court indicated that petitioner might have recovered benefits if he had been the victim of "an *unforeseen* calamity" (Appellate Decision at 10; A-38). Still later, the court held that petitioner could not recover, inasmuch as no accident had occurred, but rather an injury had resulted from voluntary activity, "which proceeding normally as planned, predictably cause[d] the employee . . . injury" (Appellate Decision at 12; A-40).

In summary, the appellate court clearly grounded its conclusion that petitioner had not suffered an "accident" in Tennessee state-law decisions which have applied the "accidental means" and "accidental results" distinction to deny accidental insurance coverage benefits to persons who have suffered injuries as a result of voluntary activities. The court adopted the rationale that, although the *results* may have been accidental, the underlying causes of the accidents were voluntary activities, which a third-party objective observer might, in hindsight, conclude were potentially hazardous and could have resulted in injury. As the First Circuit Court of Appeals noted in the *Wickman* case, this harsh and outmoded analysis of what constitutes an "accident" within the terms of insurance policy coverage has been rejected in numerous jurisdictions as being contrary to common sense and the understanding of the average person.

The First Circuit in *Wickman* undertook an analysis of the term "accident" in a manner consistent with the public policies underlying ERISA, and concluded that under the emerging federal common law of ERISA, whether or not an insured has suffered an "accident" may not be determined by an objective analysis of the facts or activities leading up to the injury, but must be determined with re-

gard to the subjective expectations of the insured, giving great latitude to the insured in favor of coverage, and taking into account the insured's personal characteristics and experiences.

Applying the federal common law of ERISA, as developed by the First Circuit in *Wickman*, to the instant facts, it is manifest that petitioner suffered an "accident" as a result of lifting a motor with his co-workers on October 6, 1987. Although petitioner readily concedes that prior to the lifting incident he suffered from a degenerative disc disease, it is also undisputed that prior to the lifting incident the petitioner had been working in a fairly strenuous position with his employer for several years, and had never suffered the sort of totally debilitating injury which he suffered as a result of the motor-lifting incident on any prior occasion when engaged in what was, for petitioner, fairly routine work. There is no evidence in the record below to indicate that petitioner subjectively expected to injure himself by lifting the motor on October 6, 1987.

Thus, applying the federal common law of ERISA, as developed in the First Circuit in the *Wickman* case, the petitioner undoubtedly suffered an "accident" and should be entitled to disability insurance benefits under his ERISA insurance plan. However, in denying petitioner benefits under this plan, the Sixth Circuit has clearly enunciated a different and much harsher construction of the federal common law of ERISA in determining what constitutes an "accident," thus adhering to the antiquated and inequitable law on this subject developed by the courts of the State of Tennessee, and thereby denying petitioner any insurance benefits whatsoever.

The stark distinction between the approaches taken to the resolution of this issue by the Sixth Circuit Court of Appeals in the instant case and by the First Circuit Court

of Appeals in the *Wickman* case presents a clear split in the federal circuits, which should be resolved by this Court, so as to eliminate the possibility of future contradictory decisions by other courts of appeal. Furthermore, the split in the federal circuits presented by the instant case and the *Wickman* case clearly involves an important issue of federal law which has not been, but should be, resolved by this court.

Without doubt, the question of what constitutes an "accident" within the terms of insurance coverage under an ERISA-controlled insurance plan is bound to arise in innumerable future cases of ERISA-related litigation. If a *uniform* federal common law of ERISA on this most basic question of coverage under an accidental insurance plan is not charted by this Court, the result will be innumerable conflicting appellate decisions in the future, in both the state and federal appellate systems, which will make an ERISA beneficiary's recovery of benefits dependent upon his or her state of residence, rather than upon the merits of a particular claim under a uniform federal law.

In order to implement the congressional intent in enacting ERISA, to resolve the current split in the federal circuits presented by the instant case and by the *Wickman* case, and to chart a clear and uniform development of the federal common law of ERISA, this Court should grant petitioner's petition, reverse the decision of the court below, and adopt the subjective analysis approved by the First Circuit Court of Appeals in *Wickman* as the uniform federal common law of ERISA, applicable in all ERISA litigation in all state and federal courts.

II.THE COURT BELOW ERRED IN FAILING TO APPLY THE FEDERAL COMMON LAW OF ERISA TO CONSTRUE THE INSURANCE POLICY EXCLUSION PROVISIONS OF PETITIONER'S ERISA DISABILITY INSURANCE POLICY COVERING ACCIDENTS "RESULTING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES," THEREBY DENYING PETITIONER HIS RIGHTS TO DISABILITY INSURANCE BENEFITS. THIS ERROR BY THE COURT BELOW IS IN CONFLICT WITH THE DECISIONS OF OTHER FEDERAL CIRCUIT COURTS OF APPEAL REGARDING AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, RESOLVED BY THIS COURT, CONSISTENT WITH THIS COURT'S PRIOR DECISIONS REGARDING ERISA.

In *Adkins v. Reliance Standard Life Insurance Co.*, *supra*, the United States Court of Appeals for the Fourth Circuit held that under the emerging federal common law of ERISA, where an accident insurance policy governed by ERISA provides for coverage only for losses "resulting directly and independently of all other causes from bodily injury caused by accident," such an exclusionary clause will *not* operate to deny accident benefits to an insured, where the insured, prior to an accidental injury, suffered from a preexisting illness or disease which was made significantly worse by the accident in question. The *Adkins* court noted that a literal construction of such an exclusionary clause might result in a denial of accidental insurance benefits wherever an insured aggravated a previously existing condi-

tion through an accident. The court concluded that such a literal interpretation of such an exclusionary clause would not be consistent with the underlying purposes of ERISA and would lead to unduly harsh results in the denial of accidental benefits to beneficiaries of ERISA accident insurance plans. Accordingly, the court held that, in the cases of such exclusionary clauses, a preexisting illness or disease would not be considered as a cause contributing to otherwise accidental disability, unless it was shown to have substantially contributed to the resultant disability. Moreover, the court held that the fact that a preexisting illness or disease might render a person predisposed or more susceptible to an injury did not necessarily amount to a showing of a substantial contributing cause to an otherwise accidental injury so as to preclude the recovery of accident insurance benefits. The court held that this analysis was consistent with this Court's admonition to promote the interests of employees and beneficiaries in ERISA plans.

In *Adkins*, the insured beneficiary under a group accidental disability insurance plan governed by ERISA stepped into a hole inside a coal mine and injured his back, resulting in his permanent total disability (the 1985 accident). The administrator of the ERISA plan denied disability insurance benefits to the insured, on the grounds that the 1985 accident had not, independently of all other factors, rendered the insured totally and permanently disabled, but rather that the 1985 accident aggravated a preexisting back condition of the insured. The administrator cited the policy exclusions of the insurance policy in question, which provided that the policy covered only losses "resulting directly and independently of all other causes," and concluded that, inasmuch as the 1985 accident had combined with the insured's preexisting back condition to render the insured totally and permanently disabled, the 1985 accident had not "directly and *independently*" caused the insured's total and permanent disability. The adminis-

trator refused to pay any benefits to the insured, based on the policy exclusions. The United States District Court for the Southern District of West Virginia granted the insurance company's motion for summary judgment, concluding that the insured's preexisting back condition had contributed to his total and permanent disability, thus rendering the insured ineligible for benefits because the 1985 accident had not been the sole and independent cause of the insured's ultimate disabled condition.

The United States Court of Appeals for the Fourth Circuit reversed the decision of the district court, holding that the district court's analysis led to a result which was too harsh to have been applied in an ERISA case, where insurance policies were to be construed with the interests of employees and beneficiaries in mind. The appellate court noted that, were it to adopt the stringent construction urged upon it by the insurer, an ERISA claimant would have to be in perfect health at the time of his or her most recent accidental injury before the insurance policy would provide any benefits, and that this was a condition hardly ever obtained by the average person. 917 F.2d at 796.

The Fourth Circuit in *Adkins* held that a preexisting illness or disease or preexisting susceptibility to injury would not preclude the recovery of accidental disability insurance benefits under an ERISA plan which purports to provide coverage only for losses resulting directly and independently of all other causes, notwithstanding the fact that a preexisting illness or disease or susceptibility to injury contributed to a disability or loss also caused in part by an accident suffered during the policy coverage period. The court held that in order for such a preexisting condition to preclude coverage for loss suffered during the policy coverage period, the preexisting condition must combine with the accident during the policy period to constitute a "substantial contributing cause" of the accident.

Having adopted this rule of construction as the emerging federal common law of ERISA, the appellate court remanded the case in *Adkins* to the district court for the district court to make a determination as to whether the insured's preexisting back condition had not merely contributed to the 1985 accident to produce a total and permanent disability, but had in fact been a substantial contributing cause of the 1985 injury.

The Fourth Circuit decision in *Adkins* reads, in pertinent part, as follows:

> [I]n order to recover under such policies as the one here involved, and with . . . a stringent construction, a claimant would have to be in perfect health at the time of his most recent injury before the policy would benefit him, and that of course, is a condition hardly obtained, however devoutly to be wished.
>
> In 84 A.L.R.2d 176 is the extensive Annotation "Pre-existing physical condition as affecting liability under accident policy or accident feature of life policies."
> . . .
>
> The Annotation explains that the courts are divided in their construction of the insuring clauses which insure for disability arising from accidental bodily injuries "directly and independently of all other causes." One group of cases would permit recovery where there is disability following an accident, although there may have been some pre-existing injury or disability, on the ground that the pre-exist-

ing disease or infirmity is a remote cause of the disability. Another group of cases has denied recovery when the insured's pre-existing physical condition contributed to or cooperated with a more immediate cause in producing the disability.

. . . .

We think [the] solution is to take a middle ground as has been taken by Kentucky in *Colonial Life & Acc. Ins. Co. v. Weartz*, 636 S.W.2d 891 (Ky.Ct. App. 1982). In *Weartz*, a claim was made on an accident insurance policy which insured against loss resulting from accidental bodily injury "directly, independently and exclusively of all other causes." This language in the insuring clause is almost precisely that in issue here. Certainly it is no more favorable to the insured. The claimant in that case had slipped at work while carrying a bathtub, injuring his back and causing his disability. He had previously had an injury to his back. The court held that the fact of a pre-existing injury to the claimant's back was not enough to bar recovery. It went on to state the rule in such cases as follows:

"[A] pre-existing infirmity or disease is not to be considered as a cause unless it substantially contributed to the disability or loss. . . . *[A] 'pre-disposition' or 'susceptibility' to injury, whether it results from congenital weakness or from previous illness or injury, does not necessarily amount*

> *to a substantial contributing cause. A mere 'relationship' of undetermined degree is not enough."*
>
> 636 S.W.2d at 894.
>
> We think the Kentucky rule is appropriate and we adopt it. It is neither all that the plaintiff asks for, nor is it as strict as the Virginia rule or the rule in *QuesTech*. We think, however, that it gives effect to the [United States Supreme] Court's admonition to promote the interests of the employees and beneficiaries in employee benefit plans. *Firestone*, 489 U.S. at 110-114, 109 S.Ct. at 954-56.

Id. at 796-97 (emphasis added).

Applying the rule adopted by the Fourth Circuit in *Adkins* to the instant facts, it is manifest that the October 6, 1987 accident in this case was the precipitating causal event leading to the petitioner's total and permanent disability. As noted by the expert testimony at trial, the "accident" in October [1987] did precipitate the petitioner's removal from work (Appellate Decision at 5; A-33).

The petitioner in the instant case has consistently conceded that his preexisting back condition may have predisposed him to the injury precipitated by the October 6, 1987 lifting incident. However, the petitioner has always contested any suggestion that this preexisting back condition substantially contributed to the October 6, 1987 injury, and the record certainly does not establish that the petitioner's preexisting condition substantially contributed to cause the injury precipitated by the 1987 accident. In light of the

above, applying the standards enunciated by the Fourth Circuit in *Adkins*, with respect to construction of the particular insurance policy exclusion language used both in the *Adkins* insurance policy and in the instant insurance policy, consistent with the emerging federal common law of ERISA, the petitioner was not precluded from receiving disability insurance benefits under the policy in question in this case, even though a literal reading of the exclusion provisions of the policy would have mandated this result due to petitioner's preexisting condition.

However, applying the harsh analysis adopted by the Sixth Circuit in reviewing the instant case, the petitioner was denied benefits under his insurance policy because the court chose to "adhere to the literal language of [the] accident insurance contract" (Appellate Decision at 9-10; A-37), including the language providing that coverage would be provided only for losses which resulted absolutely independently of any other conceivable contributing cause. Indeed, the appellate court placed its greatest reliance on a literal reading of this exclusionary language in denying petitioner's claims, holding that "*most importantly for us*, Lingerfelt's situation falls within the clear language of the policy exclusions" (Appellate Decision at 11; A-38).

As the foregoing clearly indicates, the decisions of the Fourth Circuit Court of Appeals in *Adkins* and the Sixth Circuit Court of Appeals in the instant case are clearly in conflict with respect to an important question of federal law which has not, but which should be, resolved by this Court. As with the definition of the term "accident," the construction of insurance policy exclusion clauses in insurance policies governed by ERISA is doubtless the sort of question which may reasonably be anticipated to recur innumerable times in the future with respect to claims for ERISA benefits. Although this issue has been the subject of a considerable body of developed law in the state appel-

late courts, the construction of exclusionary terms such as the one involved in this case, in ERISA policies, is a relatively new problem. Consistent with the policies underlying the enactment of ERISA, and the prior decisions of this Court, petitioner would respectfully submit that the definitional questions regarding the instant policy should be resolved by this Court so as to chart a *uniform* federal common law of ERISA with respect to the construction of ERISA-governed insurance policies, so as to insure harmony among the federal circuits, and so as to prevent development of 50 different sets of federal common-law rules of ERISA, each applicable to a respective state, thus thwarting the efforts of Congress to create a uniform and reliable federal law governing employee benefits.

Because the approach taken by the Fourth Circuit Court of Appeals in *Adkins* appears to be more consistent with the ameliorative purposes behind ERISA than the harsh approach taken by the Sixth Circuit in giving literal effect to the exclusionary clauses in the insurance policy in question, petitioner respectfully submits that this Court should grant the petitioner's petition, reverse the court below, and adopt the rule set forth by the Fourth Circuit in *Adkins* as the federal common law of ERISA with respect to ERISA-governed insurance policy exclusion clauses.

CONCLUSION

For the foregoing reasons, the petitioner, Edward Lingerfelt, respectfully requests that this Court grant this petition and issue a writ of certiorari to the Sixth Circuit Court of Appeals.

Respectfully submitted,

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APPENDIX A

[filed February 9, 1990]

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

EDWARD LINGERFELT	)	
	)	NO. CIV-2-89-206
V.	)	
	)	
COMMERCIAL INSURANCE COMPANY OF NEWARK, N.J., and CONTINENTAL INSURANCE COMPANY)	)	

MEMORANDUM OPINION

The trial of this case on its merits was conducted for two days before the undersigned on January 25 and 26, 1990, without the intervention of a jury. The following findings of fact and conclusions of law are made pursuant to Rule 52(a), Federal Rules of Civil Procedure.

I. STATEMENT OF THE CASE

Plaintiff Edward Lingerfelt was employed as a chemical operator at Nuclear Fuel Services, Inc. [NFS] when on October 6, 1987, he suffered a back injury. Defendants Commercial Insurance Company of Newark, N.J. [Commercial Insurance] and Continental Insurance Company [Continental Insurance] are the insurance underwriters and administrators of an accident disability insurance plan in which the plaintiff had participated as a contributing member during his period of employment with NFS. It is noted that defendant Continental Insurance is a subsidiary of defendant Commercial Insurance and that these defendants' interests

are, for all practical purposes, identical in this lawsuit.

Procedurally, Mr. Lingerfelt, the plaintiff in this case, originally sued defendants Commercial Insurance, Continental Insurance, and NFS. In his complaint, he alleged that jurisdiction exists under the Employee Retirement Income Security Act of 1974 [ERISA], 29 U.S.C. § 1132(e), or, in the alternative, under 28 U.S.C. § 1332 and based on diversity of citizenship. Defendants Commercial Insurance and Continental Insurance filed answers to the complaint. [Doc. 3]. NFS filed a motion to dismiss or for summary judgment [Doc. 5, 5a], arguing that it was not a proper party defendant to the lawsuit. Before any action was taken by the Court in regard to NFS's motion to dismiss, the parties filed a proposed agreed order, which was entered by this Court, dismissing NFS as a party from this lawsuit and ordering that the cause should continue as to defendants Commercial Insurance and Continental Insurance.

At the trial of this cause, the plaintiff testified that he took out an insurance policy called the Voluntary Accident Insurance Plan and that he could not recall what year this insurance policy went into effect. He estimated that he paid approximately $16.00 a month in premiums and that he, not his employer NFS, maintained the subject plan since the time it started. He alleged in his complaint that he (and not NFS) filed his claim for total disability with defendant Commercial Insurance and defendant Continental Insurance, as provided in the subject plan. He further alleged that he has complied with all requirements of the policy for making a claim for the total disability benefits of $250,000. His compliance with the requirements for making a claim, including filing a written proof of loss, is not contested.

The policy at issue provides that, by way of exclusions,

there is no coverage of loss resulting from illness or disease. [*See* Exhibit 4, page 2]. The policy also provides that the insured may recover for permanent total disability "resulting directly and independently of all other causes from bodily injuries caused by accident occurring while this policy is in force as to an insured person." [*See* Exhibit 4, page 8].[1] The policy defines permanent total disability as follows:

> If injury occurring after the effective date of coverage and commencing within 365 days after an accident causes continuous total disability for 12 continuous months and you are judged to be permanently and totally disabled (unable to engage in each and every occupation or employment for compensation or profit for which you are reasonably qualified by reason of your education, training or experience), you will be paid the Principal Sum less any amount paid or payable under the policy as the result of the same accident.

[*See* Exhibit 4, page 2].

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[1]This language quoted hereinabove is taken from a pamphlet which is a summary of the Voluntary Accident Insurance Plan for Hourly Employees of Nuclear Fuel Services, Inc. The master plan issued by defendant Commercial Insurance was also entered into evidence as Exhibit 43. The master plan and the summary plan contain virtually the same wording and language. However, the Sixth Circuit Court of Appeals has held that, in regard to differences between a summary of the plan and the master plan, the court is bound to follow the summary plan. *See Edwards v. State Farm Mutual Auto Insurance Co.*, 851 F.2d 134 (6th Cir. 1988).

In this case, the plaintiff alleges that he became totally and permanently disabled from his occupation with NFS and any other occupation as a result of an accident in which he was involved on October 6, 1987; and that because he is totally and permanently disabled and has complied with all requirements of the subject policy for making a claim for the total disability benefit, he is entitled to recover the principal sum of the policy ($250,000) from the defendant. Finally, he also argues that he is entitled to recover attorneys' fees and costs in addition to the lump sum disability benefit of $250,000; and an award of prejudgment interest from the date that his application was denied (September 30, 1988) through the date of the trial of this case (January 25 and 26, 1990).

The defendants admit that the plaintiff complied with all requirements of the subject policy for making a claim pursuant to the policy; however, they deny that the plaintiff is entitled to recover on this cause of action. Specifically, they argue that the plaintiff was not involved in an "accident" within the meaning of or terms of the contract; that he did not suffer a "loss resulting directly and independently of all other causes" within the meaning of or the terms of the contract; that his alleged disability is based in whole or in part on degenerative disc disease to the back and, therefore, is a "disease" specifically excluded from coverage by the terms of the contract; and that the plaintiff is not totally and permanently disabled within the meaning or terms of the contract.

The parties contend that this action arises under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* Specifically, the action arises under 29 U.S.C. § 1132(e). ERISA preempts state causes of action. 29 U.S.C. § 1144; *Pilot Life v. Dedeaux*, 481 U.S. 41-56, 107 S.Ct. 1549, 1557, 95 L.Ed.2d 39, 53 (1987).

Until recently, the standard which this Court applied in regard to ascertaining the validity of the defendant's actions under the policy was whether the defendant acted in an arbitrary and capricious manner in denying benefits to the plaintiff. *See, e.g., Cook v. Pension Plan for Salaried Employees of Cyclops Corp.*, 801 F.2d 865 (6th Cir. 1986); *Moore v. Reynolds Metal Company Retirement Program for Salaried Employees*, 740 F.2d 454, 457 (6th Cir. 1984), *cert. denied* 469 U.S. 1109, 105 S.Ct. 786, 83 L.Ed.2d 780 (1985). However, the standard was recently changed by the United States Supreme Court in the case of *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. ___, 109 S.Ct. 248, 103 L.Ed.2d 80 (1989), which holds that this Court must exercise a *de novo* standard of review over the actions of the defendant insurance companies. As stated by Judge Edgar in the case of *Schiller v. Mutual Benefit Life Insurance Co.*, 713 F.Supp. 1064 (E.D. Tenn. 1989),

> In its *de novo* review of [the defendant's] actions, this Court is to look to the "federal common law" for guidance. *Firestone*, 489 U.S. at ___, 109 S.Ct. at 954-955, 103 L.Ed.2d at 92-93. In *Pilot Life v. Dedeaux*, the Supreme Court has said that courts are to develop substantive federal law derived from the federal policy regarding private welfare and pension plans in a fashion similar to the way that the courts have fashioned substantive federal law under section 301 of the Labor Management Relations Act of 1947 ("LMRA") in accordance with the policy of our national labor laws. 481 U.S. at 56-57, 107 S.Ct. at 1556-1558, 93 L.Ed.2d at 52-53.
>
> In *Firestone*, the Supreme Court has

> indicated that if the ERISA plan does not give the employer or administrator discretionary or final authority to construe uncertain contract terms, the courts are to review the employee's claim as it would any contract claim "by looking to the terms of the plan and other manifestations of the parties intent." 489 U.S. at ___, 109 S.Ct. at 955, 103 L.Ed.2d at 94.

Schiller, supra at 1065-1066.

In order to ascertain whether, under the contract terms, the plaintiff suffered a loss caused by or resulting from an illness or disease, which is excluded under the terms of the policy, and whether he meets the terms of the policy which insure him "against loss resulting directly and independently of all other causes from bodily injuries caused by accident occurring while this policy is in force", the undersigned must review the facts of this case. In this regard, the undersigned makes the following findings of fact pursuant to Rule 52(a), Federal Rules of Civil Procedure.*II. FINDINGS OF FACT*

A. HISTORY OF PLAINTIFF'S BACK CONDITION:

The plaintiff was born on June 20, 1940, and has obtained a high school education. On February 6, 1987, he was hired by NFS as a production operator, a job position which is also referred to as a chemical operator. Mr. Lingerfelt had a variety of duties and responsibilities in this job, ranging from painting portions of the NFS facilities to demolition work involving the moving and carrying of heavy containers and equipment. It was undisputed that the plaintiff's work required him to engage in medium to heavy work and, on occasion, lift in excess of 100 pounds in order to fulfill his responsibilities.

The medical records of the plaintiff reveal that he has had complaints of back pain as far back as March of 1973. [Exhibit 24]. He testified that in 1974, he missed work for approximately four to five months because of his lower back pain. He was treated by Dr. T. J. Ellis and hospitalized in April of 1974 in regard to his complaints of low back pain. Dr. Ellis noted that the plaintiff told him he had been suffering said back pain for approximately five or six months and that the back pain had worsened two weeks prior to his admission to Memorial Hospital, Inc., of Johnson City, Tennessee. Upon admission, Dr. Ellis reported the plaintiff's height to be five feet eleven inches and his weight to be 227 pounds. A physical examination of the plaintiff's extremities revealed tenderness over the L-4 interspace in the midline of the back. Dr. Ellis also made the following findings:

> There is some slight tenderness across the left sciatic nerve superiorally, but no sciatic notch tenderness. He is able to flex his back enough to get his fingertips to knee level. He bends fairly well to the right and left, however bending to the left gives midlumbar pain without any irradiation. Straight leg raising is possible to about 70 degrees estimated bilaterally before he had hamstring tightness. No subjective numbness in the lower extremity.

[Exhibit 24]. Plaintiff was treated conservatively during hospitalization and was discharged to outpatient care after four days of hospitalization. The final diagnosis by Dr. Ellis was that of lumbar disc syndrome.

In March of 1974, the plaintiff sought treatment from Dr. Beaver, at which time he was diagnosed as suffering from acute low back strain resulting from having lifted

something at work. Initially, he was treated conservatively as an outpatient, but was eventually admitted for a period of hospitalization. [Exhbibit 27].

In June of 1975, the plaintiff again injured his back. Said injury occurred in the course of his employment and as a result of lifting a tube. [Exhibit 18]. The plaintiff consulted Drs. Ellis and Beaver. Dr. Beaver opined that the plaintiff suffered a thirty-five percent disability to the body as a whole. He further restricted the plaintiff from engaging in any type of employment requiring repeated or strenuous lifting, pushing, or stacking. He limited the plaintiff from lifting more than twenty-five pounds and opined that the plaintiff needed to alternate between sitting and standing. He also stated "[a]ny significant strenuous work causes a flare up. He is seen intermittently with bouts of flare up with increased pain and spasm, but this is not considered an operable situation. He needs to get into a lighter type of work." [Exhibit 27]. It is further noted that Dr. Mullins also examined the plaintiff in regard to his back problems and diagnosed him as suffering from chronic lumbosacral strain. He opined that the plaintiff should not return to the type of work which would require heavy lifting, bending, straining, climbing, pulling, etc., and further opined that he should perform only light work. [Exhibit 33]. It is noted that these restrictions are virtually identical to those imposed on the plaintiff after his injury sustained in October, 1988, and which is the subject of this lawsuit.

As a result of this injury, the plaintiff entered into a compromise settlement and lump sum payment under the Workmen's Compensation Act with NFS and Travelers Insurance Company. [Exhibit 13]. In that state law action, the parties agreed upon a settlement on a permanent partial disability of forty-two percent to the body as a whole. Furthermore, NFS approved his absence from work for long-term disability commencing December 24, 1975 and

continuing until his return to work on August 6, 1979. [Exhibit 1]. During his absence from work, he continued to receive treatment for his back. [Exhibit 25].

It is noted that, pursuant to an insurance policy carried by an insuring company other than the defendants in the case at hand, the plaintiff applied for accidental permanent total disability. In this application, he alleged accidental permanent total disability as a result of the incident on June 24, 1975. [Exhibit 18]. Plaintiff's application pursuant to said accidental permanent total disability insurance policy was denied.

Upon the plaintiff's return to work in August of 1979, Roland Bailey of NFS stated that the plaintiff should not lift more than twenty-five pounds or engage in repeated stooping, pushing or pulling, or much step climbing. He further stated that the plaintiff "should be counseled as to [his] restrictions and instructed not to perform work that would violate these restrictions." [Exhibit 34]. In this regard, the plaintiff testified that he initially performed only light work upon his return to his position as a chemical operator. However, he stated that he felt as though he could perform more strenuous work and after approximately six weeks, he returned to engaging in the heavy work which he had performed prior to his injury.

The plaintiff again received treatment for his back problem in 1984, at which time he was admitted to Johnson City Medical Center Hospital for ten days. During his hospitalization, he was followed by Dr. B. A. Richardson, who stated that the plaintiff was admitted to the hospital because of "marked tightening of the chest, marked pulmonary congestion, elevated temperature, and also some low back pain and GI bleeding and rectal bleeding." [Exhibit 17]. While hospitalized, the plaintiff's back was x-rayed, revealing marked narrowing of the lumbosacral disc. At

this time, Dr. Richardson opined that the plaintiff was suffering from degenerative arthritis.

In 1986, the plaintiff again sought treatment for his back pain. [Exhibits 9, 28, 29]. This time said treatment was sought from Dr. Kennedy of the Watauga Orthopedic Professional Association, Inc. Dr. Kennedy found that the plaintiff was showing signs of improvement both subjectively and objectively. He further stated that the plaintiff's

> CT scan at NFH showed multiple level degenerative disc disease but no evidence of any acute lesion which we could definitely attribute to his most recent industrial injury. It does not appear that he would benefit from surgery.
>
> I plan to recheck him in 2 weeks, at which time hopefully we can return him to work.

[Exhibit 29].

In November of 1986, Dr. Kennedy again stated that the plaintiff had made satisfactory progress in recovering from his low back pain. At this time, he released the plaintiff to return to work, stating that there was no evidence of permanent physical impairment which could be attributed to the recent work-related injury. He further stated:

> I think the most important thing [Mr. Lingerfelt] has gained probably has been the concept of various techniques for preventing recurrence of low back pain. He will need to continue to be careful with his back for the rest of his life be-

cause of his multiple level painful degenerative disc disease.

[Exhibit 28].

This concludes the review of the plaintiff's medical condition prior to October 8, 1987, the date upon which he alleges he became permanently and totally disabled within the meaning of the subject policy.

B. INCIDENT OF OCTOBER 8, 1987:

On October 8, 1987, the plaintiff was engaged in demolition work. He and co-worker Isaac (Ikie) Price and Supervisor Claude Tims attempted to lower a motor from a roof of a building to the floor. The plaintiff described this motor as weighing at least 250 pounds. The three men tied a rope around the motor and began to lower it to the floor when the plaintiff felt a "catch" in his lower back. [Exhibit 5]. He further testified that he felt the rope jerk immediately prior to feeling the "pop" or "catch" in his back, and he was not sure whether the motor had bumped a ladder or what had caused it to jerk. It is noted that the plaintiff's application for accidental disability benefits does not mention that the rope jerked when he and the other two men were lowering the motor.

However, reasons set forth hereinafter, the undersigned finds that it is not necessary to resolve any conflict in the evidence as to whether the rope jerked or not, as this point is immaterial. Plaintiff reported his injury to his supervisor and completed the necessary accident report forms. NFS required him to undergo an examination performed by the company doctor, Dr. Hyder. Subsequent to his examination by Hyder, plaintiff returned to the Watauga Orthopedic Professional Association where he was treated by Dr. Calvin Johnson. [Exhibit 9].

In November of 1987, Dr. Johnson wrote a letter in which he summarized his findings regarding the plaintiff's back condition subsequent to the October 7, 1987 incident. He noted the plaintiff's complaints of severe pain and limitation of intersegmental movement and a moderate degree of overall limitation. Upon review of the plaintiff's x-rays taken a year prior to this incident, Dr. Johnson noted the plaintiff's marked degenerative disc disease at L5-S1 and severe disc degeneration at L3-4. Dr. Johnson advised the plaintiff not to return to work until he underwent therapy, with the hope that said therapy would bring improvement to his condition. However, Dr. Johnson stated that he could not say with certainty that the plaintiff would be able to return to work due to his significant degenerative disc and facet disease. [Exhibit 9]. The plaintiff remained under Dr. Johnson's treatment and has never been released from his care or authorized to return to work.

The plaintiff filed a worker's compensation claim against NFS and Liberty Mutual Insurance Company. In a deposition taken of Dr. Johnson in November of 1988 in regard to the plaintiff's worker's compensation claim, Dr. Johnson stated that in February of 1988, he felt the plaintiff had probably reached maximum improvement although he was still suffering a great deal of back pain. Dr. Johnson opined that the plaintiff could not return to his job at NFS since this job involved heavy work. He restricted the plaintiff from engaging in repetitive lifting, bending, stooping, twisting, climbing ladders or stairs, vigorous or strenuous pushing or pulling, or repeated or vigorous jostling. At the time of this deposition, Dr. Johnson opined that the plaintiff had a permanent impairment of twenty percent to the body as a whole, as a result of his back, at least twelve percent of which could be attributed to the recent injury. [*See* Deposition of Dr. Calvin Johnson, Exhibit 9, page 10].

Dr. Jewell of Bristol Orthopedic Associates, Inc., con-

curred with Dr. Calvin Johnson's impairment rating of twenty percent permanent impairment relative to the body as a whole as a result of his back condition, twelve percent attributable to the October of 1987 injury and eight percent preexisting this injury. Dr. Jewell also opined that the plaintiff could not perform his past job due to the amount of lifting involved. He stated that the plaintiff specifically needed to avoid prolonged standing, re-petitive bending, or lifting. It is further noted that Dr. Jewell opined that the plaintiff could perform a light work job within the confines of these limitations. [Exhibit 16].

Mr. Lingerfelt entered into a settlement agreement with NFS and Liberty Mutual Insurance Company on the worker's compensation claim. In this settlement agreement, the plaintiff received a lump sum payment of $20,000, which was the equivalent of uncommuted permanent partial disability to the body for approximately 29.8 percent permanent partial disability to the body as a whole of Mr. Lingerfelt. [Exhibit 14].

In the trial of the case at hand, Dr. Alex Williams' testimony via deposition was that he would have restricted the plaintiff from performing medium to heavy work prior to the October, 1987 injury and that, based on prior CT scan reports and x-rays, the plaintiff's degenerative arthritic condition was the reason for placing this limitation on the plaintiff. [*See* Exhibit 22, page 12]. He further testified that the plaintiff suffers from a degenerative disc disease at L3 and L5 with a pars inarticularis defect at the L5 level. [Exhibit 22, pages 6, 9].

Plaintiff's treating orthopedic specialist, Dr. Calvin Johnson of Johnson City, Tennessee, testified by deposition that the plaintiff's degenerative disc problems had been going on for quite some time. [Exhibit 21, pages 9, 10]. He further stated that the plaintiff's injury of October,

1987 was the precipitating factor which removed him from the work force, but that there was no question that he had also suffered other back injuries. "I have trouble separating the whole thing because there was certainly not one specific episode that is the origin of this man's back pain. There is a precipitating episode. There is an accident in October that did precipitate his removal from work and has led to his failure to return to gainful employment." [Exhibit 21, page 14].

Dr. Norman Hankins, a board-certified vocational expert, testified at the trial of this case on the plaintiff's behalf. As a vocational expert, Dr. Hankins interviewed the plaintiff and conducted numerous intelligence and vocational tests designed to measure the plaintiff's aptitudes and skills. He also reviewed the opinions of Dr. Johnson and his recommendation that the plaintiff sit for a maximum of 45 minutes, walk for a maximum of one and one-half hours, and alternate his positions. He noted that Dr. Johnson indicated that the plaintiff's pain is great. In addition, Dr. Hankins reviewed a deposition of Dr. Williams. After reviewing all this evidence, Hankins opined that the plaintiff's pain would prevent him from sustaining regular work; and that there are no jobs for someone, such as the plaintiff, whose pain renders him unreliable in the work place. He further opined that, as a practical matter, employers generally choose not to hire a person with the plaintiff's physical/medical problems but, instead, hire applicants who have no health problems.

Dr. David Sabatino, also a vocational expert, testified on behalf of the defendants. He, of course, disputed the findings of Hankins and opined that the plaintiff could be retrained vocationally and perform a number of jobs existing in the economy. He further opined, initially, that the plaintiff is a malingerer. His explanation of how he concluded that the plaintiff is a malingerer was vague and un-

clear. Therefore, his testimony on this point is rejected.

This concludes the review of the evidence regarding the plaintiff's back condition. As previously stated, the plaintiff received workers' compensation as a result of this injury. He was also approved for long-term disability by NFS and presently is receiving long-term disability benefits pursuant to the group long-term disability insurance provided by NFS. [Exhibit 19]. He is also receiving Social Security disability insurance benefits, which were awarded to him on April 11, 1989. [Exhibit 11]. In this regard, an Administrative Law Judge reviewed the plaintiff's claim and found that the plaintiff suffers from degenerative spinal disease at multiple lumbar levels. He further noted that the plaintiff's treating orthopedic surgeon, Dr. Johnson, has opined that he could perform sedentary work; that Dr. Norman Hankins, a vocational expert, opined that, given the limitations of Dr. Johnson, the claimant could not perform a full range of sedentary work but suffers a 100 percent vocational disability; that Dr. Johnson's limitations include no repetitive lifting, bending, stooping, twisting, climbing ladders or stairs, and vigorous or strenuous pushing or pulling or repeated or vigorous jostling. After reviewing the evidence, the Administrative Law Judge opined that the plaintiff's musculoskeletal problems reduced his exertional capability to the extent that he is incapable of performing any work available in substantial numbers in the national economy, and that he has a residual functional capacity insufficient for the performance of substantial gainful activity, sedentary or otherwise. Therefore, he found the plaintiff entitled to a period of disability commencing October 9, 1987 and to disability insurance benefits accordingly.

III. CONCLUSIONS OF LAW AND REVIEW UNDER ERISA

As stated at the outset, this Court is to review the plaintiff's claim filed pursuant to ERISA as it would any contract claim "by looking to the terms of the plan and other manifestations of the parties' intent." *Schiller*, *supra*, at 1066, quoting *Firestone*, *supra*, 103 L.Ed.2d at 94. After reviewing the facts of this case and looking at the terms of the subject plan, the undersigned finds that the plaintiff did not suffer a "loss resulting directly and independently of all other causes", but instead is unable to return to his former occupation with NFS as a result of a "illness or disease" which he has been suffering for over fifteen years and which excludes him, under the terms of the policy, from receiving benefits. The proof shows that the plaintiff's severe and painful degenerative disc disease and arthritis combined and concurred with any injury he may have sustained in October of 1987 to cause his present condition. His own physician stated that he is suffering from a severe disc disease which is a significant factor in his present disability.

As previously stated, the Supreme Court has stated that courts should develop substantial federal law derived from the federal policy regarding private welfare and pension plans in a fashion similar to the way that the courts have fashioned federal law under § 301 of the Labor Management Relations Act of 1947. *Schiller*, *supra*, at 1065. In this regard, and as stated by the *Schiller* court, "[i]nsurance policies have been traditionally interpreted in accordance with state law. Under § 301 of the LMRA, it is possible to resort to state law in interpreting collective bargaining agreements if state law is compatible with federal policy. Any state law so utilized, however, becomes absorbed as federal law." *Schiller*, *supra*, at 1066, quoting *Textile Workers Union v. Lincoln Mills*, 353 U.S. 448, 457, 77 S.Ct. 912,

918, 1 L.Ed.2d 972 (1957). The undersigned finds that state law is in agreement with this Court's interpretation of the subject policy.

The undersigned notes that in formulating rules of law to govern aspects of the employee benefit field, the court must be guided by the general policies underlying ERISA.

> The general objective of this Act is to increase the number of individuals in employer-financed benefit plans. Congress wanted to assure that those who participate in the plans actually receive the benefits they are entitled to and do not lose these as the result of unduly restrictive provisions or lack of sufficient funds.

Helms v. Monsanto Co., Inc., 728 F.2d 1416 (11th Cir. 1984), quoting 1974 *U.S. Code Cong. & Ad. News*, 4639, 4670, 4676-77. As will be addressed more fully hereinafter, the subject plan in which the plaintiff was participating was a totally voluntary plan. In other words, employees of NFS were not required to be enrolled in the voluntary accident insurance plan but were merely offered the opportunity to enroll in said plan. Any insurance they obtained pursuant to this plan was not funded by the employer, NFS. Instead, NFS funded a different disability insurance plan, pursuant to which the plaintiff is presently receiving benefits.

In regard to formulating a rule of law on the question of whether the plaintiff is unable to recover because of the provision in the insurance policy excluding coverage of injury from "disease", the undersigned has found virtually no federal cases. The undersigned has read the case of *Ore v. Aetna Life Insurance Co.*, 435 F.2d 957 (6th Cir. 1970). In *Ore*, the plaintiff sought recovery of accidental death benefits under a group life policy for the death of her insured

husband. As the jurisdiction of the *Ore* court was based on diversity of citizenship, the court looked to the law developed by the State of Tennessee on this point and found:

> It is also the general rule that if the insured, at the time of the alleged accidental injury, was also suffering from a disease and the disease aggravated the effects of the accident, and actively contributed to the disability or death occasioned thereby, there can be no recovery under the policy.

Ore, *supra*, at 959, quoting *Britton v. Prudential Insurance Co. of America*, 205 Tenn. 726, 730-731, 330 S.W.2d 326, 328 (1959).

The undersigned further finds that Tennessee's rule on this issue is the same rule applied by the majority of the state courts when faced with interpreting exclusionary clauses in accidental death and disability insurance policies, similar to the exclusionary clause at issue in the case at hand. In this regard, 131 A.L.R. 240, 242 makes the following pertinent statement:

> Where, however, at the time he sustained an accidental injury the insured was suffering from a disease or other infirmity, and such disease or infirmity proximately caused, or substantially contributed to, his death or injury, it is generally held that no recovery can be had under a policy insuring in substance against death or injury resulting, independently of all other causes, from accidental means, or variations of such provisions, and containing no express exception with respect to dis-

> ease, infirmity, etc. This conclusion was reached in the following cases, which are set out infra, II a.

Then follows a list of cases from virtually every state. Application of this majority rule to the case at hand, which is what Judge Edgar did in the *Schiller* case, leads the undersigned to conclude that because of the plaintiff's preexisting degenerative disc disease, he was suffering from an "illness or disease" which caused or contributed to his present condition and prevents him from recovering under the terms of the policy.

Finally, the undersigned agrees with the defendants' argument that to allow the plaintiff to recover under the facts of this case would result in an inappropriate modification of the customary and restrictive accidental disability contract language used in this particular policy and which has developed through years of extensive state court litigation. As stated by the defendants, "any such modification would effectively rewrite the accidental disability policy into a much broader injury or illness policy which would be the equivalent of a long-term disability policy." [File Doc. 40, page 5]. To hold for the plaintiff would amount to liberalization of the contract terms and provide coverage which was not contemplated when the policy was issued and for which no premiums were paid. In this regard, the plaintiff paid approximately $17.00 a month for $250,000 of coverage provided by the voluntary accident insurance plan as opposed to payment of $2.45 per $100 of payroll in premiums for coverage pursuant to the disability insurance plan from which he presently receives benefits. By mathematical calculation, on an annual salary of $25,000, the annual premium for the disability insurance plan would be approximately $612.50. It can be inferred from the difference in the amount of these premiums that the voluntary accident insurance plan provides much more restrictive

coverage than does the disability insurance plan under which the plaintiff presently receives benefits.

IV. CONCLUSIONS OF LAW AND REVIEW UNDER STATE LAW

As stated at the outset in the section above entitled "Statement of the Case", Mr. Lingerfelt originally sued his employer, NFS, in addition to the defendant insurance companies. In his complaint, he alleged that jurisdiction exists pursuant to ERISA or, in the alternative, pursuant to 28 U.S.C. § 1332 for diversity of citizenship. However, NFS's principal place of business is at 205 Banner Hill Road, Erwin, Tennessee 37650. Therefore, NFS is deemed a citizen of the State of Tennessee; and as long as it was a party to this lawsuit, there was no complete diversity of citizenship. 28 U.S.C. § 1332(c). However, as noted in the undersigned's statement of the case, an agreed order was entered dismissing NFS as a defendant in this case. Because NFS has been dismissed from the lawsuit and NFS was not an indispensable party, jurisdiction based on diversity of citizenship was acquired by the court upon the dismissing action as to the nondiverse party. *Grant County Deposit Bank v. Campbell*, 194 F.2d 469 (6th Cir. 1952); *Dadew v. Tenn. Copper Co.*, 179 F.2d 245, *aff'd.* [sic] 218 U.S. 357, 54 L.Ed. 1069, 31 S.Ct. 81 (1910). Therefore, this Court also has jurisdiction of this case as predicated on diversity of citizenship and existing pursuant to 28 U.S.C. § 1332.

The issue of whether this Court should exercise jurisdiction of this case as based on diversity of citizenship or under ERISA was not raised by the parties. Furthermore, the defendants did not contest or litigate the question of whether the insurance policy in question is an ERISA employee benefit plan. However, the undersigned questions whether the subject policy is an ERISA employee benefit

plan as defined by the statute and the regulations passed by the Secretary of Labor in relation to this statute. In this regard, the Department of Labor has issued regulations defining ERISA plan requirements. 29 C.F.R. § 2510.3-1(j) (1989) states factors which will preclude an insurance plan from ERISA designation:

> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation [in] the program is completely voluntary for employees or members;
>
> (3) The sole function [sic] of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

The existence of an ERISA plan is a question of fact to be answered in the light of all the surrounding circumstances from the point of view of a reasonable person. *Credit Managers Association v. Kennesaw License Accident Insurance*, 609 F.2d 617, 625 (9th Cir. 1987), citing *Dono-*

van v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) *en banc*. The party which asserts that ERISA applies has the burden of establishing the existence of a plan which would invoke ERISA's exclusive remedy provisions. *See Murphy v. Inexso Oil Co.*, 611 F.2d 570, 573 (5th Cir. 1980), and *Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 99 n. 4 (9th Cir. 1988). As previously stated, the defendants did not raise this issue during the trial of this cause; however, the undersigned has some question as to whether the proof established the existence of a plan which would invoke ERISA's exclusive remedy provisions.

The uncontradicted testimony during the trial of the case was that participation in the program was completely voluntary for employees. Furthermore, the policy itself is entitled the "Voluntary Accident Disability Insurance" policy. The regulations promulgated by the Department of Labor and quoted hereinabove mandate that ERISA does not apply to a group-type insurance program offered by an insurer to employees under which the participation in the program "is completely voluntary for employees". 29 C.F.R. § 2510.3-1(j)(2). It would appear from the facts of this case that the insurance program at issue is not an ERISA plan in that the employer, NFS, apparently did not contribute to the payment of premiums but merely deducted from the plaintiff's paycheck his payment and forwarded it to the defendant companies on his behalf. 29 C.F.R. § 2510.3-1(j)(3). Furthermore, the participation by the employees in the program was voluntary. Apparently, the sole function of the employer was to publicize the program and to collect premiums. When faced with a similar factual scenario, the Southern District of Mississippi found that the plan at issue was not an employee welfare benefit plan as defined by ERISA and 29 C.F.R. § 2510.3-1(j) and, therefore, ERISA had no application. *Terry v. Protective Life Insurance Co.*, 717 F.Supp. 1203, 1205 (S.D. Miss. 1989). *Also see Taggart Corp. v. Life and Health Benefits*

Administration, 617 F.2d 1208, 1211 (5th Cir. 1980); *Bond v. Life Insurance Co. of North American*, C.A. No. 88-4244 (E.D. La. Nov. 7, 1989); and *Ellington v. Metropolitan Life Insurance Co.*, 696 F.Supp. 1237, [sic] (S.D. Ind. 1988).

If the jurisdiction of this Court does not exist pursuant to ERISA but is predicated, instead, on diversity of citizenship, then the case clearly must be decided under Tennessee law pursuant to a breach of contract claim. Application of Tennessee law to the case at hand, [sic] results in the conclusion that the plaintiff is not entitled to recover.

As previously stated in this opinion, the general rule applied in Tennessee is as follows:

> [I]f the insured, at the time of the alleged accidental injury, was also suffering from a disease, and the disease aggravated the effects of the accident, and actively contributed to the disability or death occasioned thereby, there can be no recovery under the policy.
>
> . . . .
>
> Where, however, at the time he sustained an accidental injury the insured was also suffering from a disease or infirmity, and such disease or infirmity proximately cause [sic], or substantially contributed to, his death or injury, it is generally held that no recovery can be had under a policy insuring in substance against death or injury resulting, independently of all other causes, from accidental means, or variations of such provisions, and con-

> taining no express exception with respect to disease, infirmity, etc. *Briton v. Prudential Ins. Co. of America, supra*, 205 Tenn. at 730-731, 330 S.W.2d at 328.

Ore v. Aetna Life Insurance Co., 435 F.2d 957, 959 (6th Cir. 1970).

Additionally, under Tennessee law, the plaintiff has failed to prove that he was involved in an "accident" as that word is traditionally defined by the Tennessee courts. Accident disability insurance contract language has been litigated exhaustively in Tennessee courts. In these cases, the word "accident" has been interpreted as "an injury that may be caused by a voluntary, natural ordinary movement, executed exactly as was intended." *Baker v. National Life & Accident Insurance Co.*, 298 S.W.2d 715, 717 (Tenn. 1956). A voluntary act which unexpectedly causes an individual to sustain an injury has generally been found not to meet the definition of "accident" and, therefore, any such injury is excluded from coverage under an accidental disability insurance policy. *Baker, supra*. In other words, "a person may do certain acts, the result of which produces unforeseen consequences resulting in which is termed an accident; yet it does not come within the terms of this contract". *Baker, supra*; *Stone v. Fidelity & Casualty Co.*, 133 Tenn. 672, 182 S.W.2d 252 (1916). Tennessee decisions distinguish between "accidental means" and "accidental results". *See Seeley v. Pilot Fire & Casualty Co.*, 222 Tenn. 33, 432 S.W.2d 58, 61 (1968).

In the case at hand, the facts reveal that the plaintiff's back injury occurred subsequent to his engaging in heavy work, specifically the lowering of a motor. This incident and the resulting injury might be termed an "accidental result". However, the means by which the injury occurred were not accidental. The plaintiff was engaged in a volun-

tary act, that is, the act of intentionally lowering the 200-pound motor. His bodily injury did not result "solely through external, violent, and accidental means". *Seeley, supra*, at 61. As stated by the defendant,

> Had a piece of heavy equipment fallen without warning upon Edward Lingerfelt as he walked beneath it, the plaintiff would have sustained an "accidental" injury under the terms of the defendant's policy. Since plaintiff was engaged in the usual performance of his NFS duties and making voluntary movements when he "felt a sudden onset of pain" neither his back "injury" nor his subsequent disability are accidental under the terms of the defendant's policy.

[File Doc. 15, page 14].

In summary, the undersigned makes a legal finding, in the alternative to the legal findings made pursuant to ERISA, that if this case is treated as an insurance contract case and reviewed under Tennessee law, the plaintiff still is not entitled to recover and judgment must be entered for the defendants.

Finally, the undersigned finds that a determination of whether the plaintiff is permanently disabled under the terms of the subject policy is unnecessary. By reason of the Court's finding that the plaintiff simply does not qualify for benefits because he did not suffer a loss resulting directly and independently of all other causes and because, instead, he suffered a loss by reason of a disease that was preexisting, the issue of whether he is totally disabled is pretermitted. The question of whether the plaintiff is permanently and totally disabled as defined by the plan ("unable to en-

gage in each and every occupation or employment for compensation or profit for which you are reasonably qualified by reason of your education, training or experience") is a difficult one. The Social Security Administration applies a definition of disability virtually identical to the definition contained in the subject insurance plan. Therefore, the Administrative Law Judge's finding that the plaintiff is totally disabled is persuasive evidence of permanent and total disability of the plaintiff. However, the record also contains evidence that the plaintiff could perform sedentary, or perhaps even light, work activity if he underwent vocational rehabilitation or retraining. Also, even the plaintiff's treating physician found only a twenty percent permanent impairment in the context of the plaintiff's worker's compensation case which arose out of the October, 1987 injury. The doctor further opined that this twenty percent medical impairment could be broken down as follows: twelve percent occurred as a result of his October, 1987 injury, and eight percent preexisted the October, 1987 injury.

There is positively no doubt in the undersigned's mind that the plaintiff suffers a very serious back problem which has resulted in a variety of restrictions to his movement. However, it is harder to determine whether he is permanently and totally disabled; and because this question has in effect been pretermitted by the finding that the plaintiff does not qualify for benefits under the relevant portions of the subject plan, the undersigned makes no finding in this regard.

In conclusion, the Court finds that the plaintiff is not entitled to recover disability benefits under the subject policy.

ENTER:

/s/ Joe A. Tilson
JOE A. TILSON
UNITED STATES MAGISTRATE

APPENDIX B

[filed February 9, 1990]

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

EDWARD LINGERFELT	)	
	)	NO. CIV-2-89-205
V.	)	
	)	
COMMERCIAL INSURANCE	)	
COMPANY OF NEWARK,	)	
N.J., and	)	
CONTINENTAL INSURANCE	)	
COMPANY	)	

ORDER

For the reasons set out in the Memorandum Opinion entered this day in this action, the Clerk is hereby DIRECTED to enter judgment in favor of the defendants and against the plaintiff.

SO ORDERED:

/s/ Joe A. Tilson
JOE A. TILSON
UNITED STATES MAGISTRATE

APPENDIX C

[filed February 5, 1991]

No. 90-5320

THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

EDWARD LINGERFELT,
Plaintiff-Appellant,

v.

NUCLEAR FUEL SERVICES, INC.

Defendant,

and

COMMERCIAL INSURANCE CO. OF NEWARK, NEW JERSEY; and CONTINENTAL INSURANCE CO.,
Defendants-Appellees.

On Appeal from the United States District Court for the Eastern District of Tennessee

_____/

BEFORE: NELSON and RYAN, Circuit Judges; and LIVELY, Senior Circuit Judge.

RYAN, Circuit Judge. Plaintiff Edward Lingerfelt appeals the magistrate's judgment in favor of Commercial Insurance Company of Newark, New Jersey, with respect to Lingerfelt's claim for accident benefits under an employees' group-based accident insurance plan. The issues on appeal are 1) whether the magistrate's fact finding that disease rather than accident caused the employee's back injury is clearly erroneous, and 2) whether, assuming the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1001, *et seq.*, applies,

ERISA policy dictates that the insurance plan be construed to cover Lingerfelt's injuries.

We conclude that the magistrate's fact finding that disease caused the employee's injury is not clearly erroneous, and that even assuming ERISA governs this case, ERISA policy does not suggest that we construe an insurance plan clearly intended to cover only injury due to accident to cover injury due to disease.

I.

Lingerfelt, a chemical operator at Nuclear Fuel Services, Inc. (NFS), suffered a sudden recurrence of back problems on October 6, 1987, while helping to lower a 250-pound motor from the roof of a building.

Lingerfelt was a contributing member of an accident disability insurance plan with Commercial Insurance Company. The plan policy was entitled, "Voluntary Accident Insurance Plan for Hourly Employees of Nuclear Fuel Services, Inc." NSF [sic] employees were not required to participate in the plan, and NSF did not help fund the plan, which was funded entirely by the employees themselves. Under the policy terms, Lingerfelt was covered "24 hours a day, 365 days a year against loss from any type of accident which occurs in the course of business or pleasure, including accidents on or off the job, occurring in or away from home, traveling by train, airplane, automobile, or other public and private conveyance (except as noted in "Exclusions" below)." Under the heading "Exclusions," the policy stated, "The policy excludes loss resulting from intentionally self-inflicted injuries or suicide or any attempt thereat; accident occurring while insured is on full-time active duty in any Armed Forces; pregnancy, childbirth, *illness or disease . . .*"

Under the heading "PERMANENT TOTAL DISABILITY," the policy further provided:

> If injury occurring after the effective date of coverage and commencing within 365 days after an accident causes continuous total disability for 12 continuous months and you are judged to be permanently and totally disabled (unable to engage in each and every occupation or employment for compensation or profit for which you are reasonably qualified by reason of your education, training or experience), you will be paid the Principal Sum less any amount paid or payable under the policy as the result of the same accident.

A less conspicuous part of the policy clarified that the employee was insured "against loss resulting directly and independently of all other causes from bodily injuries caused by accident occurring while this policy is in force . . . ."

Claiming that he was totally and permanently disabled as a result of the recurrence of his back problems, Lingerfelt filed a policy claim for disability benefits with Commercial Insurance Company and its subsidiary Continental Insurance Company. When his policy claim was denied, Lingerfelt brought suit in federal district court against Commercial Insurance Company, Continental Insurance Company (a subsidiary of Commercial Insurance), and NFS. He alleged jurisdiction under ERISA or alternatively under diversity of citizenship. The parties voluntarily dismissed NFS and Continental Insurance Company from the lawsuit.

Lingerfelt alleges that he was totally and permanently

disabled as a result of the back injury and therefore is entitled to the $250,000 disability benefit under the policy. The insurance company refuses to pay on the grounds that Lingerfelt was not the victim of an "accident" as covered by the policy. Specifically, the company alleges that the back injury was due in whole or part to degenerative disc disease.

As required by *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. ___, 103 L.Ed.2d 80, 95-96 (1989), the magistrate evaluated the insurance companies' decision to deny benefits *de novo*. Following a trial, the magistrate found that plaintiff had a long history of back problems dating back to at least March 1973. These problems sometimes had required hospitalization and Lingerfelt had sought treatment for the problems periodically up until the time of the October 6, 1987, injury.

In June of 1975, for example, Lingerfelt injured his back while lifting some tubing on the job. A doctor gave his opinion that Lingerfelt suffered a thirty-five percent disability to his body as a whole due to that accident. The doctor restricted the plaintiff from lifting more than twenty-five pounds and noted that "[a]ny significant strenuous work causes a flare up. . . . He needs to get into a lighter type of work." Due to that injury, Lingerfelt received a lump sum payment under the Workers' Compensation Act, and he was absent from work due to long-term disability from December 24, 1975, until August 6, 1979. When Lingerfelt returned to work, he initially did only "light" work but then felt he could perform heavier labor and eventually returned to the heavy work he had been doing before the June 1975 injury.

In 1984, Lingerfelt was hospitalized again, partly due to low back pain. At that time a doctor thought Lingerfelt had degenerative arthritis. In 1986 a different doctor con-

cluded Lingerfelt "showed multiple level degenerative disc disease." In November of 1986, this doctor released Lingerfelt to return to work but concluded, "He will need to continue to be careful with his back for the rest of his life because of his multiple level painful degenerative disc disease."

After the October 6, 1987, accident at issue here, Dr. Johnson, who had been following Lingerfelt's condition for several years, stated in effect that he could not say with certainty that Lingerfelt would be able to return to work in view of Lingerfelt's significant degenerative disc and facet disease. In a later deposition, Dr. Johnson stated in effect that while the October 1987 injury was the precipitating factor which removed Lingerfelt from the work force, there was no question that Lingerfelt also had suffered other back injuries. Dr. Johnson stated, "I have trouble separating the whole thing because there was certainly not one specific episode that is the origin of this man's back pain. There is a precipitating episode. There is an accident in October that did precipitate his removal from work and has led to his failure to return to gainful employment."

The magistrate evaluated Lingerfelt's claim filed pursuant to ERISA as the magistrate would evaluate any contract claim, by looking to the terms of the agreement and other indicia of the parties' intent. In view of the evidence just discussed, the magistrate concluded:

> After reviewing the facts of this case and looking at the terms of the subject plan, [I find] that the plaintiff did not suffer a 'loss resulting directly and independently of all other causes,' but instead is unable to return to his former occupation with NFA [sic] as a result of a 'illness or disease' which he has been suffering for

> over fifteen years and which excludes him, under the terms of the policy, from receiving benefits. The proof shows that the plaintiff's severe and painful degenerative disc disease and arthritis combined and concurred with any injury he may have sustained in October of 1987 to cause his present condition. His own physician stated that he is suffering from a severe disc disease which is a significant factor in his present disability.

The magistrate also noted that Lingerfelt received a lump-sum workers' compensation payment and also receives Social Security disability benefits and long-term disability benefits under a separate group long-term disability insurance plan.

II.

The magistrate's fact findings are subject to the clearly erroneous standard of review. *Cf. Anderson v. Bessemer*, 470 U.S. 564, 573 (1985). The magistrate found that "plaintiff's severe and painful degenerative disc disease and arthritis combined and concurred with any injury he may have sustained in October of 1987 to cause his present condition." This finding, based upon the magistrate's careful review of medical records and testimony documenting a fifteen-year history of back problems, is not clearly erroneous.

III.

Determining whether Lingerfelt's injuries were covered by the insurance contract involves a mixed question of law and fact. Therefore, this determination is subject to *de novo* review. *Blackburn v. Foltz*, 828 F.2d 1177, 1181 (6th

Cir. 1987), *cert. denied*, 485 U.S. 970 (1988).

According to the language of a relatively easy-to-understand booklet distributed to NFS employees, the insurance plan very plainly and conspicuously excluded from coverage any losses resulting from illness and disease. Somewhat less conspicuously, the plan clarified that permanent disability benefits would be paid only due to disability resulting "directly and independently of all other causes from bodily injuries caused by accident." In view of the magistrate's fact finding that disease rather than accident caused Lingerfelt's back injuries, it might seem a foregone conclusion that Lingerfelt could not recover under this policy. When, despite his disc disease and his doctors' warnings, Lingerfelt persisted[1] in lifting heavy weights, the resulting disability more closely resembled an inevitable consequence than an unforeseen accident. We are not dealing here with a Workers' Compensation program or with a general long-term disability insurance plan – two programs under which Lingerfelt has received or is receiving benefits as a result of the November 1987 injury. We instead are dealing with an insurance policy covering only *accidents*, and Lingerfelt did not have an "accident" within any reasonable meaning of that term. To allow Lingerfelt to recover under the policy would distort the parties' initial bargain by changing the allocation of risk which the parties had in mind when they agreed to the amount of the insurance premium.

Nonetheless, Lingerfelt argues that even if state law would require following the literal language of the contract, federal policy under ERISA mandates a different

[1]It is unclear whether Lingerfelt was required to lift heavy weights in order to keep a job with NFS.

outcome.[2] ERISA does preempt state-law causes of action insofar as they "relate to" employee benefit plans. 29 U.S.C. § 1144; *Pilot Life v. Dedeaux*, 481 U.S. 41, 56 (1987). Additionally, Congress intended that "a federal common law of rights and obligations under ERISA-regulated plans would develop." *Id.* Stated differently, "ERISA's broad preemption provision makes it clear that Congress intended to establish employee benefit plan regulation as an exclusive federal concern, with federal law to apply exclusively, even where ERISA itself furnishes no answer." *In re White Farm Equipment Co.*, 788 F.2d 1186, 1191 (6th Cir. 1986). However, Lingerfelt can point to nothing in the federal common law in this area which would indicate that we should depart from the literal meaning of the language of his accident insurance contract.

We find no federal appellate case where the court was called upon to decide as a matter of federal common law under ERISA, whether an accident insurance plan should, despite its explicit language to the contrary, be read to cover injuries caused substantially or entirely by a known, pre-existing disease. *Compare Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794 (4th Cir. 1990). However, we regard as instructive language from a recent First Circuit opinion:

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[2]Throughout this litigation both parties have agreed that ERISA law and policies govern the insurance contract at issue, and the pretrial order grounded jurisdiction on that basis. However, the magistrate expressed some doubt about whether ERISA actually covered this insurance contract. Accordingly, he decided to consider Lingerfelt's claim under the alternative assumptions that 1) ERISA and federal common law apply, and 2) Tennessee contract law applies. The magistrate determined that under either assumption, Lingerfelt was not entitled to the accident benefits. Since neither party disputes that ERISA applies and since its applicability would not change our holding in this case, we assume without deciding that ERISA does apply.

> [T]he "federal common law of rights and obligations," *Pilot Life*, 107 S.Ct. at 1558, while still in formation, must embody common-sense canons of contract interpretation. Notwithstanding the ennobling purposes which prompted passage of ERISA, courts have no right to torture language in an attempt to force particular results or to convey . . . nuances the contracting parties neither intended nor imagined. To the exact contrary, *straightforward language in an ERISA-regulated insurance policy should be given its natural meaning.*

Burnham v. Guardian Life Ins. Co., 873 F.2d 486, 489 (1st Cir. 1989) (emphasis added and citation omitted). We believe that under the emerging federal common law, we should adhere to the literal language of accident insurance contracts except where public-policy considerations dictate a different course. Lingerfelt can point to no such countervailing public-policy considerations here.

The Eleventh Circuit has commented upon the public policy underlying ERISA:

> [I]n formulating these laws [governing various aspects of the employee benefit field] courts must be guided by the general policies underlying ERISA. The general objective of [ERISA] is to increase the number of individuals in employer-financed benefit plans. Congress wanted to assure than [sic] those who participate in the plans actually receive the benefits they are entitled to and do not lose these as the result of *unduly*

restrictive provisions or lack of sufficient funds.

Helms v. Monsanto, 728 F.2d 1416, 1420 (11th Cir. 1984) (citing H.R.Rep. No. 93-807, 93rd Cong., 2nd Sess. 3, *reprinted in* 1974 *U.S. Code Cong. & Ad. News*, 4639, 4670, 4676-77) (emphasis added). A provision in an accident insurance policy providing in effect that the policy does not cover losses resulting from disease rather than from accident is not an "unduly restrictive" provision in our view. If this were a case where the employee's disease were subtle or latent, where the employee had not been warned against precisely the outcome that ensued, or where the disease contributed only negligibly to what was essentially an unforeseen calamity, then perhaps the insurance company would not be justified in denying benefits. In such a case, the employee's reasonable expectations might be upset by denying benefits. Here, however, we perceive nothing unconscionable or misleading about the accident policy on its face, and most importantly for us, Lingerfelt's situation falls within the clear language of the policy exclusions.

Lingerfelt cites several federal court cases to support his position, but all these cases are inapposite on two grounds: 1) the injured employees could point to some sudden, unexpected event that fits the common-sense notion of an accident, and 2) the injured employees were members of the United Mine Workers of America and covered by the UMWA disability plan. In *Odom v. United Mine Workers of America*, 687 F.2d 843, 847 (6th Cir. 1982), a case upon which Lingerfelt relied at oral argument, the miner slipped while pulling a pipe wrench and then fell from a platform. Such an event indisputably is an accident, not a sudden recurrence of a known, pre-existing disease. The fall from the platform permanently damaged the miner's kidneys, which had been suffering from renal disease before the accident. We analyzed the issue of

whether the mining accident *caused* the permanent injury as follows:

> [Defendant's] own "proximate cause principle" set forth in its "Health Services Card Processing for Disabled Mine Workers," provides:
>
> If the mine accident aggravated a pre-existing condition to the extent that the person became totally disabled, or if the mine accident occurred after a non-mine related injury and the two injuries combined resulted in total disability, then the mine worker shall be deemed to be totally disabled as a result of a mine accident. This rule applies even if evidence establishes that the mine related condition is only a small percentage of the disability.
>
> This principle is commonly found in disability benefits programs, see 1 A. Larson, Law of Workmen's Compensation, section 12.20 (1978), and is akin to the tort principle that tortfeasors must take their victims as they find them. It is irrelevant whether a person with normal kidneys would have sustained permanent damage to his kidneys as a result of an accident. The question is whether the accident contributed in some part to the disability of appellant.
>
> We conclude that there is not substantial evidence in the record to support a finding that the accident *did not* contribute to

> appellant's disability. To the contrary, the evidence overwhelmingly establishes that the accident *did* contribute to his disability. Therefore, the decision of the district court affirming the decision denying disability benefits must be reversed.

Id. at 847 (emphasis in original).

Odom reveals that the special regulations governing disability plans available to UMWA members help explain the outcome in the cases Lingerfelt cites. Additionally, the time-honored rule that one takes one's victim as one finds him does not apply where the employee, acting contrary to his physician's orders, engages in an activity which, proceeding normally as planned, predictably causes the employee the very injury against which his physicians had warned him.

Lingerfelt raises a number of miscellaneous policy arguments which, he believes, indicate that he should recover benefits under this accident policy. However, these arguments do not apply to the case of an insurance policy which explicitly insures only against accidents and which, from the employee's point of view, is supplemental to a more general policy that covers disability resulting from disease as well as disability resulting from accident. We believe that the employee's reasonable expectations were not upset in this case.

IV.

The magistrate's order conforms to the plain language of the accident insurance contract and does not conflict with public policy. Accordingly, for the reasons given above, the magistrate's judgment is **AFFIRMED**.